

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0052639</u> Facility Name: <u>Avantara Long Grove</u> Address: <u>1666 Rfd Checker Rd</u> <u>Long Grove</u> <u>60047</u> Number City Zip Code County: <u>Lake</u> Telephone Number: <u>(847) 419-1111</u> Fax # <u>(847) 419-1119</u> HFS ID Number: _____ Date of Initial License for Current Owners: <u>2/1/2014</u> Type of Ownership: <table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td>☐</td><td>IRS Exemption Code _____</td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☒</td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></td><td></td></tr></table> In the event there are further questions about this report, please contact: Name: <u>Steven N. Lavenda</u> Telephone Number: <u>(847) 282-6300</u> Email Address: _____	☐	VOLUNTARY, NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	☐	IRS Exemption Code _____	☐	Corporation	☐	Other _____			☒	"Sub-S" Corp.					☐	Limited Liability Co.					☐	Trust					☐	Other _____			II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/20</u> to <u>12/31/20</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment. <table><tr><td rowspan="3">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____ (Date) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td rowspan="5">Paid Preparer</td><td>(Signed) _____ <u>04/29/2021</u></td></tr><tr><td>* Subject to the attached Accountants' Consulting Report (Date) _____</td></tr><tr><td>(Print Name <u>Steven N. Lavenda, CPA</u> and Title) <u>Partner</u></td></tr><tr><td>(Firm Name <u>Marcum, LLP</u> & Address) <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u></td></tr><tr><td>(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u></td></tr></table> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____ (Date) _____	(Title) _____	Paid Preparer	(Signed) _____ <u>04/29/2021</u>	* Subject to the attached Accountants' Consulting Report (Date) _____	(Print Name <u>Steven N. Lavenda, CPA</u> and Title) <u>Partner</u>	(Firm Name <u>Marcum, LLP</u> & Address) <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u>	(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>
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#	0052639	Report Period Beginning:	01/01/20	Ending:	12/31/20
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D. How many bed reserve days during this year were paid by the Department?

None (Do not include bed reserve days in Section B.)

N/A

None

Yes

YES ☐ NO ☒

YES ☐ NO ☒

Date started 02/01/2014

YES ☒ Date 02/01/2014 NO ☐

YES ☒ NO ☐ If YES, enter number
of beds certified 195 and days of care provided

IV. ACCOUNTING BASIS

Is your fiscal year identical to your tax year? YES ☒ NO ☐

* All facilities other than governmental must report on the accrual basis.

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) **78.15%**

78.15%

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/20 Ending: 12/31/20

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary		2,507	1,200,461	1,202,968		1,202,968	3,586	1,206,554			1
2	Food Purchase		1,344		1,344		1,344	6,822	8,166			2
3	Housekeeping	657	7,522	541,415	549,594		549,594	2,326	551,920			3
4	Laundry	117,281	34,822	755	152,858		152,858	158	153,016			4
5	Heat and Other Utilities			187,451	187,451		187,451	(31,355)	156,096			5
6	Maintenance	111,411	25,845	192,812	330,068		330,068	8,825	338,893			6
7	Other (specify):*											7
8	TOTAL General Services	229,349	72,040	2,122,894	2,424,283		2,424,283	(9,638)	2,414,645			8
	B. Health Care and Programs											
9	Medical Director			22,000	22,000		22,000		22,000			9
10	Nursing and Medical Records	5,893,794	396,810	102,314	6,392,918		6,392,918	116,081	6,508,999			10
10a	Therapy	236,110			236,110		236,110		236,110			10a
11	Activities	197,734	6,258	1,461	205,453		205,453	9	205,462			11
12	Social Services	373,767		2,718	376,485		376,485	6,230	382,715			12
13	CNA Training											13
14	Program Transportation			41,815	41,815		41,815		41,815			14
15	Other (specify):*							6,461	6,461			15
16	TOTAL Health Care and Programs	6,701,405	403,068	170,308	7,274,781		7,274,781	128,782	7,403,563			16
	C. General Administration											
17	Administrative	110,534			110,534		110,534	69,347	179,881			17
18	Directors Fees											18
19	Professional Services			102,650	102,650	(416)	102,234	(6,255)	95,979			19
20	Dues, Fees, Subscriptions & Promotions			138,335	138,335		138,335	(91,934)	46,401			20
21	Clerical & General Office Expenses	202,416	5,644	728,295	936,355		936,355	(279,707)	656,648			21
22	Employee Benefits & Payroll Taxes			979,726	979,726		979,726		979,726			22
23	Inservice Training & Education											23
24	Travel and Seminar			284	284		284	155	439			24
25	Other Admin. Staff Transportation			716	716		716	5,184	5,900			25
26	Insurance-Prop.Liab.Malpractice			312,963	312,963		312,963	16,216	329,179			26
27	Other (specify):*							27,795	27,795			27
28	TOTAL General Administration	312,950	5,644	2,262,969	2,581,563	(416)	2,581,147	(259,200)	2,321,947			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,243,704	480,752	4,556,171	12,280,627	(416)	12,280,211	(140,056)	12,140,155			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Avantara Long Grove #0052639 Report Period Beginning: 01/01/20 Ending: 12/31/20

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation							654,209	654,209			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,855	10,855		10,855	714,505	725,360			32
33	Real Estate Taxes					416	416	144,613	145,028			33
34	Rent-Facility & Grounds			1,680,000	1,680,000		1,680,000	(1,679,892)	108			34
35	Rent-Equipment & Vehicles			13,211	13,211		13,211	5,036	18,247			35
36	Other (specify):*							133,809	133,809			36
37	TOTAL Ownership			1,704,066	1,704,066	416	1,704,482	(27,720)	1,676,761			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		539,934	1,570,916	2,110,850		2,110,850	(46,952)	2,063,898			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			363,293	363,293		363,293		363,293			42
43	Other (specify):*			804,180	804,180		804,180	(804,180)				43
44	TOTAL Special Cost Centers		539,934	2,738,389	3,278,323		3,278,323	(851,132)	2,427,191			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,243,704	1,020,686	8,998,626	17,263,016		17,263,016	(1,018,909)	16,244,107			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(32,568)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(29,222)	30		9
10	Interest and Other Investment Income	(2,407)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(16,488)	21		18
19	Entertainment	(5,479)	21		19
20	Contributions	(69,119)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(412,878)	21		24
25	Fund Raising, Advertising and Promotional	(6,362)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(10,925)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,037,434)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,622,883)		\$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	603,974		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 603,974		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,018,909)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Rebates	\$(9,852)	21	1
2	Patient Personal Items	(686)	10	2
3	Bank Charges	(86,128)	21	3
4	Sequestration	(38,443)	21	4
5	Bldg Co - Filing Fees	(75)	20	5
6	Bldg Co - Accounting Fees	(13,540)	19	6
7	Bldg Co - Amortization	(5,888)	36	7
8	Capitalized R&M	(3,420)	06	8
9	Chamber of Commerce Dues	(510)	20	9
10	PAC Dues	(19,831)	20	10
11	Non Allowable Expense	(802,993)	43	11
12	Non Allowable Legal	(23,025)	19	12
13	Marketing License	(1,187)	43	13
14	Therapy Discount	(31,856)	39	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,037,434)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/20 Ending: 12/31/20

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary			3,586									3,586	1
2	Food Purchase	(1)		6,823									6,822	2
3	Housekeeping			2,326									2,326	3
4	Laundry			158									158	4
5	Heat and Other Utilities	(32,568)				1,213							(31,355)	5
6	Maintenance	(3,420)		11,658		1,175	(588)						8,825	6
7	Other (specify):*													7
8	TOTAL General Services	(35,989)		24,551		2,388	(588)						(9,638)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(686)		119,254					(2,487)				116,081	10
10a	Therapy													10a
11	Activities			9									9	11
12	Social Services			6,230									6,230	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				6,461								6,461	15
16	TOTAL Health Care and Programs	(686)		125,493	6,461				(2,487)				128,782	16
	C. General Administration													
17	Administrative			69,347									69,347	17
18	Directors Fees													18
19	Professional Services	(36,565)	13,540	22,766		511		(6,507)					(6,255)	19
20	Fees, Subscriptions & Promotions	(95,897)	75	3,887		1							(91,934)	20
21	Clerical & General Office Expenses	(580,193)		300,204		282							(279,707)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			155									155	24
25	Other Admin. Staff Transportation			5,184									5,184	25
26	Insurance-Prop.Liab.Malpractice		15,775	137		305							16,216	26
27	Other (specify):*			27,795									27,795	27
28	TOTAL General Administration	(712,655)	29,390	429,474		1,098		(6,507)					(259,200)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(749,330)	29,390	579,518	6,461	3,486	(588)	(6,507)	(2,487)				(140,056)	29

Summary B

12/31/20

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	\$ 1,680,000	Buffalo Property Holdings, LLC		\$	(1,680,000)	1
2	V	32	Interest	618	Buffalo Property Holdings, LLC		713,326	712,708	2
3	V	33	Real Estate Tax		Buffalo Property Holdings, LLC		140,793	140,793	3
4	V	26	Property Insurance		Buffalo Property Holdings, LLC		15,775	15,775	4
5	V	36	MIP Expense		Buffalo Property Holdings, LLC		133,809	133,809	5
6	V	20	Filing Fees		Buffalo Property Holdings, LLC		75	75	6
7	V	19	Accounting Fees		Buffalo Property Holdings, LLC		13,540	13,540	7
8	V	30	Depreciation		Buffalo Property Holdings, LLC		675,950	675,950	8
9	V	36	Amortization		Buffalo Property Holdings, LLC		5,888	5,888	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,680,618			\$ 1,699,156	\$ * 18,538	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	GPN Family Trust	50.00%	Astoria Place Skilled Nursing Facility LLC	Chicago	Buffalo Property Holdings LLC	Long Grove	Building Company	1
2	Doros Generation Trust	50.00%	Avantara Arlington	Arlington, SD	Legacy HC & Financial Services	Lincolnwood	Home Office/Bookkeeping	2
3			Avantara Armour	Armour, SD	CF St. Louis LLC	Skokie	Building Company	3
4			Avantara Arrowhead	Rapid City, SD	ML Group Design & Development	Skokie	Asset Management	4
5			Avantara Aurora	Aurora	ReMED Services LLC	Lincolnwood	Nursing Equipment	5
6			Avantara Billings	Billings, MT	Propay HR	Evanston	Payroll Processing	6
7			Avantara Clark	Clark, SD	Ecobrite Linen	Skokie	Laundry Supplies	7
8			Avantara Elgin	Elgin	Aurora Supportive Living	Aurora	Supportive Living	8
9			Avantara Evergreen Park	Evergreen Park	Terrace Gardens	Morton Grove	Assisted Living	9
10			Avantara Groton	Groton, SD	Lincolnshire Assisted Living Center	Lincolnshire	Assisted Living	10
11			Avantara Huron	Huron, SD	Wellshire Park Place	Milbank, SD	Assisted Living	11
12			Avantara Ipswich	Ipswich, SD	Wellshire Huron	Huron, SD	Assisted Living	12
13			Avantara Lake Norden	Lake Norden, SD	Lifescan Labs of Illinois	Skokie	Laboratory	13
14			Avantara Milbank	Milbank, SD				14
15			Avantara Mountainview	Rapid City, SD				15
16			Avantara North	Rapid City, SD				16
17			Avantara Norton	Sioux Falls, SD				17
18			Avantara Park Ridge	Park Ridge				18
19			Avantara Pierre	Pierre, SD				19
20			Avantara Redfield	Redfield, SD				20
21			Avantara Salem	Salem, SD				21
22			Avantara St. Cloud	Rapid City, SD				22
23			Avantara Watertown	Watertown, SD				23
24			Bella Terra Streamwood	Streamwood				24
25			Bella Terra Wheeling	Wheeling				25
26			Bethany Terrace	Morton Grove				26
27			Carlton Skilled Nursing Facility LLC	Chicago				27
28			Chalet Skilled Nursing Facility LLC	Chicago				28
29			Clark Skilled Nursing Facility	Chicago				29
30			Elmbrook Skilled Nursing Facility LLC	Elmhurst				30

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Evanston Skilled Nursing Facility LLC	Evanston				1
2			Grove at the Lake Skilled Nursing Facility LLC	Zion				2
3			Grove of Berwyn	Berwyn				3
4			Grove of Fox Valley	Aurora				4
5			Grove of St. Charles	St. Charles				5
6			Lagrange Skilled Nursing Facility LLC	Lagrange Park				6
7			Lakefront Skilled Nursing Facility LLC	Chicago				7
8			Lincoln Park Skilled Nursing Facility LLC	Chicago				8
9			Lincolnshire Living & Rehab Center LLC	Lincolnshire				9
10			Northbrook Skilled Nursing Facility LLC	Northbrook				10
11			Peterson Park Associates Limited Partnership	Chicago				11
12			Skokie Skilled Nursing Facility LLC	Skokie				12
13			Valley Skilled Nursing Facility	Billings, MT				13
14			Warren Barr Living And Rehab	Chicago				14
15			Warren Barr North Shore	Highland Park				15
16			Warren Barr South Loop	Chicago				16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietician Salary	\$	Legacy Healthcare Financial Services		\$ 3,567	\$ 3,567	15
16	V	01	Dietary Supplies		Legacy Healthcare Financial Services		19	19	16
17	V	02	Food		Legacy Healthcare Financial Services		6,823	6,823	17
18	V	03	Housekeeping		Legacy Healthcare Financial Services		2,326	2,326	18
19	V	04	Linen Replacement		Legacy Healthcare Financial Services		158	158	19
20	V	06	Maintenance Salary		Legacy Healthcare Financial Services		11,005	11,005	20
21	V	06	Repairs & Maintenance		Legacy Healthcare Financial Services		653	653	21
22	V	10	Nursing Salary		Legacy Healthcare Financial Services		91,088	91,088	22
23	V	10	Nurse/Medical Director Consultant		Legacy Healthcare Financial Services		8,597	8,597	23
24	V	10	Medical Supplies		Legacy Healthcare Financial Services		19,569	19,569	24
25	V	12	Social Service Salary		Legacy Healthcare Financial Services		6,205	6,205	25
26	V	11	Activities Program		Legacy Healthcare Financial Services		9	9	26
27	V	12	Social Service Consultant		Legacy Healthcare Financial Services		24	24	27
28	V	17	COO / Administrative Salary		Legacy Healthcare Financial Services		69,347	69,347	28
29	V	19	Professional Fees		Legacy Healthcare Financial Services		22,766	22,766	29
30	V	20	Dues / Licenses / Permits		Legacy Healthcare Financial Services		3,887	3,887	30
31	V	21	Clerical & General Wages		Legacy Healthcare Financial Services		279,800	279,800	31
32	V	21	Clerical & Office Expense		Legacy Healthcare Financial Services		20,404	20,404	32
33	V	24	Education & Seminars		Legacy Healthcare Financial Services		155	155	33
34	V	25	Travel		Legacy Healthcare Financial Services		5,184	5,184	34
35	V	26	Insurance - General		Legacy Healthcare Financial Services		137	137	35
36	V	27	Non-Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		27,795	27,795	36
37	V	34	Rent		Legacy Healthcare Financial Services		35,095	35,095	37
38	V	34	Offsite Storage / Parking		Legacy Healthcare Financial Services		108	108	38
39	Total			\$			\$ 614,721	\$ * 614,721	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	Equipment Rental		Legacy Healthcare Financial Services		468	\$	468
16	V	35	Auto Rental		Legacy Healthcare Financial Services		4,568		4,568
17	V	15	Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		6,461		6,461
18	V								
19	V								
20	V								
21	V								
22	V								
23	V								
24	V								
25	V								
26	V								
27	V								
28	V								
29	V								
30	V								
31	V								
32	V								
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$			11,497	\$ *	11,497

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	\$	CF St. Louis LLC		\$ 1,213	\$ 1,213	15
16	V	6	Repairs & Maintenance		CF St. Louis LLC		1,175	1,175	16
17	V	19	Property Valuation Fee		CF St. Louis LLC		416	416	17
18	V	19	Accounting Fees		CF St. Louis LLC		95	95	18
19	V	20	Dues & Subscriptions		CF St. Louis LLC		1	1	19
20	V	21	Office Expense		CF St. Louis LLC		282	282	20
21	V	26	Insurance		CF St. Louis LLC		305	305	21
22	V	30	Depreciation		CF St. Louis LLC		7,481	7,481	22
23	V	32	Interest Expense		CF St. Louis LLC		4,204	4,204	23
24	V	33	Real Estate Taxes		CF St. Louis LLC		3,820	3,820	24
25	V								25
26	V	34	Rent	35,095	CF St. Louis LLC			(35,095)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 35,095			\$ 18,990	\$ * (16,105)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance	\$ 24,000	ML Group Design and Development		\$ 23,412	\$ (588)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 24,000			\$ 23,412	\$ * (588)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Services	\$ 28,401	ProPay HR LLC		\$ 21,894	\$ (6,507)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 28,401			\$ 21,894	\$ * (6,507)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Medical Supplies	\$ 8,250	ReMED Services		\$ 5,763	\$ (2,487)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 8,250			\$ 5,763	\$ * (2,487)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	04	Laundry	\$ 97,252	EcoBrite Linen		\$ 97,252	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 97,252			\$ 97,252	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Laboratory	\$ 37,090	Lifescan Labs of Illinois		\$ 21,994	\$ (15,096)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 37,090			\$ 21,994	\$ * (15,096)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YESNO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Ending: 12/31/20

B. Show the allocation of costs below. If necessary, please attach worksheets.

IL478-2471

Facility Name & ID Number Avantara Long Grove# 0052639

Report Period Beginning:

01/01/20Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

Legacy Healthcare Financial Services

Street Address

3450 Oakton Street

City / State / Zip Code

Skokie, IL 60076

Phone Number

(847) 679-9797

Fax Number

(847) 683-2900

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary		Allocation	
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	(col.8/col.4)x col.6	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units		
1	01	Dietician Salary	Available Bed Days	2,540,133	53	\$ 130,303	\$ 130,303	69,540	\$ 3,567	1
2	01	Dietary Supplies	Available Bed Days	2,540,133	53	697		69,540	19	2
3	02	Food	Available Bed Days	2,540,133	53	249,220		69,540	6,823	3
4	03	Housekeeping	Available Bed Days	2,540,133	53	84,952		69,540	2,326	4
5	04	Linen Replacement	Available Bed Days	2,540,133	53	5,771		69,540	158	5
6	06	Maintenance Salary	Available Bed Days	2,540,133	53	401,986	401,986	69,540	11,005	6
7	06	Repairs & Maintenance	Available Bed Days	2,540,133	53	23,857		69,540	653	7
8	10	Nursing Salary	Available Bed Days	2,540,133	53	3,327,223	3,327,223	69,540	91,088	8
9	10	Nurse/Medical Director Consultant	Available Bed Days	2,540,133	53	314,035		69,540	8,597	9
10	10	Medical Supplies	Available Bed Days	2,540,133	53	714,824		69,540	19,569	10
11	12	Social Service Salary	Available Bed Days	2,540,133	53	226,662	226,662	69,540	6,205	11
12	11	Activities Program	Available Bed Days	2,540,133	53	335		69,540	9	12
13	12	Social Service Consultant	Available Bed Days	2,540,133	53	893		69,540	24	13
14	17	COO / Administrative Salary	Available Bed Days	2,540,133	53	2,533,078	2,533,078	69,540	69,347	14
15	19	Professional Fees	Available Bed Days	2,540,133	53	831,592		69,540	22,766	15
16	20	Dues / Licenses / Permits	Available Bed Days	2,540,133	53	141,983		69,540	3,887	16
17	21	Clerical & General Wages	Available Bed Days	2,540,133	53	10,220,453	10,220,453	69,540	279,800	17
18	21	Clerical & Office Expense	Available Bed Days	2,540,133	53	745,293		69,540	20,404	18
19	24	Education & Seminars	Available Bed Days	2,540,133	53	5,655		69,540	155	19
20	25	Travel	Available Bed Days	2,540,133	53	189,364		69,540	5,184	20
21	26	Insurance - General	Available Bed Days	2,540,133	53	4,997		69,540	137	21
22	27	Non-Nursing Payroll Taxes / Bene	Available Bed Days	2,540,133	53	1,015,274		69,540	27,795	22
23	34	Rent	Available Bed Days	2,540,133	53	1,281,940		69,540	35,095	23
24	34	Offsite Storage / Parking	Available Bed Days	2,540,133	53	3,949		69,540	108	24
25	TOTALS					\$ 22,454,338	\$ 16,839,706		\$ 614,721	25

Ending: 12/31/20

(847) 683-2900

Ending: 12/31/20

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6			
1	5	Utilities	Available Bed Days	53	\$ 44,301	\$	69,540	\$ 1,213	1
2	6	Repairs & Maintenance	Available Bed Days	53	42,932		69,540	1,175	2
3	19	Property Valuation Fee	Available Bed Days	53	15,181		69,540	416	3
4	19	Accounting Fees	Available Bed Days	53	3,453		69,540	95	4
5	20	Dues & Subscriptions	Available Bed Days	53	23		69,540	1	5
6	21	Office Expense	Available Bed Days	53	10,298		69,540	282	6
7	26	Insurance	Available Bed Days	53	11,124		69,540	305	7
8	30	Depreciation	Available Bed Days	53	273,261		69,540	7,481	8
9	32	Interest Expense	Available Bed Days	53	153,558		69,540	4,204	9
10	33	Real Estate Taxes	Available Bed Days	53	139,524		69,540	3,820	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 693,655	\$		\$ 18,990	25

Ending: 12/31/20

()

Ending: 12/31/20

()

IL478-2471

Ending: 12/31/20

IL478-2471

Ending: 12/31/20

()

Ending: 12/31/20

()

IL478-2471

Ending: 12/31/20

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Capital One		X	Mortgage			\$	20,455,780			\$	713,326	1
2													2
3													3
4													4
5													5
	Working Capital												
6	Interest Only											10,855	6
7													7
8													8
9	TOTAL Facility Related						\$	20,455,780			\$	724,181	9
	B. Non-Facility Related*												
10	Interest Income		X									(2,407)	10
11	Interest Income - Bldg Co		X									(618)	11
12	Allocated from CF St. Louis	X										4,204	12
13													13
14	TOTAL Non-Facility Related						\$				\$	1,179	14
15	TOTALS (line 9+line14)						\$	20,455,780			\$	725,360	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 133,809 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Avantara Long Grove COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0052639

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE (847) 282-6330 FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 15-31-201-082	Long Term Care Property	\$ 124,953.08	\$ 124,953.08
2. 15-31-201-083	Long Term Care Property	\$ 8,202.48	\$ 8,202.48
3. 10-23-406-034-0000	Home Office Allocation	\$ 459,532.44	\$ 3,819.67
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 592,688.00	\$ 136,975.23

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation . Facilities located in Cook County are required to provide copies of their original second installment tax bill.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2019 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

Please complete the Real Estate Tax Statement below and include it in the 2020 cost report along with a copy of your 2019 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Avantara Long Grove COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0052639

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original second installment tax bill.

A. Square Feet: 60,302

B. General Construction Type: Exterior Divit/Face BrickFrame Cinder BlockNumber of Stories 1

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility			\$ 1,482,376	1
2	Allocated from CF St. Louis, LLC			5,403	2
3	TOTALS			\$ 1,487,779	3

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

See Page 12A, Line 70 for total

Facility Name & ID Number Avantara Long Grove

0052639

Report Period Beginning:

01/01/20

Ending:

12/31/20

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		254,282	6,897		12,091	5,194	54,090	68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		\$ 15,711,799	\$ 682,847		\$ 507,222	\$ (175,624)	\$ 2,564,615	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Avantara Long Grove

0052639

Report Period Beginning:

01/01/20

Ending:

12/31/20

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 15,711,799	\$ 682,847		\$ 507,222	\$ (175,624)	\$ 2,564,615	1
2	Install New Door/Frame/Hardware	2017	11,516		20	576	576	2,304	2
3	New Ceiling & Floor In Dinnig Room, New Drywall/Floor In Utili	2017	55,960		20	2,798	2,798	10,726	3
4	Water Pump Work	2017	9,159		20	458	458	1,680	4
5	Deep Well Replacement	2017	41,615		20	2,081	2,081	6,936	5
6	New Concrete In Front Of The Ramp	2017	3,000		20	150	150	450	6
7	Repairs To Outside Walls, Foundation, Storage Room	2017	4,250		20	213	213	603	7
8	Furnished & Installed Domestic Hot Water Storage Tank	2017	23,977		20	1,199	1,199	3,398	8
9	Elevator- Door Restrictors, Car Identification Plates, And Stencil	2017	3,453		20	173	173	1,265	9
10	Installed Fire Alarm System For Corridor	2017	6,066		20	303	303	1,213	10
11	Installed Hot Water Booster	2017	14,455		20	723	723	2,891	11
12	Repaired Metal Stairway East Side Of Building	2017	4,250		20	213	213	850	12
13	Installed Breaker Panel And Connected To Transfer Switch-1St F	2017	10,570		20	529	529	2,114	13
14	Repaired Ac System In Office	2017	6,788		20	339	339	1,358	14
15	Repiped Boiler	2017	4,679		20	234	234	4,679	15
16	Ductless Ac (7,500)	2018	6,942		20	347	347	882	16
17	Replace Kitchen Drain (4,600)	2018	4,258		20	213	213	599	17
18	Hot Water Motorized Valve With Digital Controller (2,900)	2018	2,684		20	134	134	365	18
19	Built In Booster Heater (7,700)	2018	7,127		20	356	356	1,868	19
20	Replacement Of Compressor (2,550)	2018	2,360		20	118	118	619	20
21	Kitchen Plumbing, Electrical, Tile, Make Window (36,000)	2018	33,322		20	1,666	1,666	6,632	21
22	Repair Sprinkler Pipes In Room 343 (2,650)	2018	2,453		20	123	123	368	22
23	Mill & Pave West Side Lot (12,300)	2018	11,385		20	569	569	1,708	23
24	Design Fee - Kitchen Plumbing, Electrical, Tile, Make Window (2	2018	19,438		20	972	972	2,916	24
25	Add Longer Drain In Kitchen (8,700)	2018	8,053		20	403	403	1,208	25
26	Well Rehabilitation (\$30801.7)	2019	29,850		20	1,492	1,492	4,573	26
27	Sewer Line (\$4845)	2019	4,695		20	235	235	598	27
28	Installation Of Drop Ceiling Tiles In Basement (\$55,600)	2019	53,882		20	2,694	2,694	5,165	28
29	Door Protection Equipment (\$16580.79)	2019	16,068		20	803	803	1,771	29
30	Installation Of New Drywall Sheets In Basement (\$6,700)	2019	6,493		20	325	325	660	30
31	Fencing (\$2850)	2019	2,762		20	138	138	281	31
32	Repipe Surface Protection (\$2783)	2019	2,697		20	135	135	532	32
33	Mini-Split System (\$5680)	2019	5,504		20	275	275	591	33
34	TOTAL (lines 1 thru 33)		\$ 16,131,510	\$ 682,847		\$ 528,208	\$ (154,639)	\$ 2,636,415	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Avantara Long Grove

0052639

Report Period Beginning:

01/01/20

Ending:

12/31/20

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 16,131,510	\$ 682,847		\$ 528,208	\$ (154,639)	\$ 2,636,415	1
2	Storage Tank (\$6073.47)	2019	5,886		20	294	294	446	2
3	Replace Heat Exchanger In Water Heater (2,768)	2020	2,700		20	135	135	135	3
4	Repair Rooftop Exhausts & Replace Roof Top Motors (2,995)	2020	2,922		20	146	146	146	4
5	Install 2 Hot Water Storage Tanks (12,000)	2020	11,706		20	585	585	585	5
6	Replace Hot Water Heater (8,358)	2020	8,153		20	408	408	408	6
7	Repair Well Piping (5,112)	2020	4,986		20	249	249	249	7
8	Replace Boiler Control Boards (4,608)	2020	4,495		20	225	225	225	8
9	4" Leaking Piping Repair (3,420)	2020	3,336		20	167	167	167	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 16,175,694	\$ 682,847		\$ 530,417	\$ (152,430)	\$ 2,638,777	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Avantara Long Grove

0052639

Report Period Beginning:

01/01/20

Ending:

12/31/20

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 16,175,694	\$ 682,847		\$ 530,417	\$ (152,430)	\$ 2,638,777	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 16,175,694	\$ 682,847		\$ 530,417	\$ (152,430)	\$ 2,638,777	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Avantara Long Grove

0052639

Report Period Beginning:

01/01/20

Ending:

12/31/20

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment.** (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 16,175,694	\$ 682,847		\$ 530,417	\$ (152,430)	\$ 2,638,777	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 16,175,694	\$ 682,847		\$ 530,417	\$ (152,430)	\$ 2,638,777	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Avantara Long Grove

0052639

Report Period Beginning:

01/01/20

Ending:

12/31/20

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment.** (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Avantara Long Grove

0052639

Report Period Beginning:

01/01/20

Ending:

12/31/20

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment.** (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Avantara Long Grove

0052639

Report Period Beginning:

01/01/20

Ending:

12/31/20

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party								1
2	Buildings:								2
3	Allocated from CF St. Louis, LLC	2016	29,092	1,351	35	831	(520)	4,156	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis, LLC	2016	180,623	4,456	20	9,031	4,575	45,156	9
10	Allocated from CF St. Louis, LLC	2017	4,192	103	20	210	106	838	10
11	Allocated from CF St. Louis, LLC	2019	37,998	937	20	1,900	962	3,800	11
12	Allocated from CF St. Louis, LLC	2019	1,999	49	20	100	51	100	12
13									13
14	Allocated from Legacy HC	2018	216		20	11	11	32	14
15	Allocated from Legacy HC	2020	163		20	8	8	8	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 254,282	\$ 6,897		\$ 12,091	\$ 5,194	\$ 54,090	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 254,282	\$ 6,897		\$ 12,091	\$ 5,194	\$ 54,090	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 254,282	\$ 6,897		\$ 12,091	\$ 5,194	\$ 54,090	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,181,033	\$ 582	\$ 118,103	\$ 117,521	10	\$ 683,963	71
72	Current Year Purchases	56,885	2	5,689	5,687	10	5,689	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,237,918	\$ 584	\$ 123,792	\$ 123,208		\$ 689,651	75

D. Vehicle Costs. (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	18,901,391
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	683,431
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	654,209
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(29,222)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	3,328,428

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES
- ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocated from Legacy Healthcare				108			5
6								6
7	TOTAL				\$ 108			7

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-
-

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
-
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☐ NO
16. Rental Amount for movable equipment: \$ 13,679
- Description: See Attached

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Legacy Healthcare		\$	\$ 4,568	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 4,568	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2021	\$
13.	/2022	\$
14.	/2023	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 596,086	\$		\$ 596,086	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			123,259			123,259	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			760,411			760,411	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				335,091		335,091	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached					91,160	204,843		296,003	13
14	TOTAL			\$		\$ 1,570,916	\$ 539,934		\$ 2,110,850	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 147,756	\$ 658,764	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,000,621	1,000,621	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		10,323	6
7	Other Prepaid Expenses	652,981	652,981	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	582,307	794,426	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,383,665	\$ 3,117,115	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	70,844	1,553,221	13
14	Buildings, at Historical Cost		12,961,389	14
15	Leasehold Improvements, at Historical Cost	1,224,994	3,451,662	15
16	Equipment, at Historical Cost	980,648	1,585,347	16
17	Accumulated Depreciation (book methods)	(1,309,972)	(3,957,240)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached	6,075,073	6,554,693	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 7,041,587	\$ 22,149,072	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,425,252	\$ 25,266,187	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,044,884	\$ 1,044,938	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	259,699	259,699	30
31	Accrued Taxes Payable (excluding real estate taxes)	313,705	313,705	31
32	Accrued Real Estate Taxes(Sch.IX-B)		139,813	32
33	Accrued Interest Payable		58,981	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	2,740,438	2,740,438	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,358,726	\$ 4,557,574	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		20,455,780	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	1,895,833	427,268	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,895,833	\$ 20,883,048	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,254,559	\$ 25,440,622	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,170,693	\$ (174,435)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,425,252	\$ 25,266,187	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,091,659	1
2	Restatements (describe):		2
3	Depreciation	(203,671)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,887,988	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	282,705	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 282,705	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,170,693	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Avantara Long Grove

0052639

Report Period Beginning:

01/01/20

Ending:

12/31/20

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 18,751,195	1
2	Discounts and Allowances for all Levels	(6,862,579)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,888,616	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,789,167	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,789,167	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	318,885	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	71,993	19
20	Radiology and X-Ray		20
21	Other Medical Services	21,216	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 412,094	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,407	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,407	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	1,453,437	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,453,437	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 17,545,721	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,424,283	31
32	Health Care	7,274,781	32
33	General Administration	2,581,563	33
	B. Capital Expense		
34	Ownership	1,704,066	34
	C. Ancillary Expense		
35	Special Cost Centers	2,915,030	35
36	Provider Participation Fee	363,293	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 17,263,016	40
41	Income before Income Taxes (line 30 minus line 40)**	282,705	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 282,705	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 8,876,761	44
45	Private Pay - Net Inpatient Revenue	440,305	45
46	Medicare - Net Inpatient Revenue	2,352,205	46
47	Other-(specify) Insurance	219,345	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 11,888,616	49

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,120	2,273	\$ 166,052	\$ 73.05	1
2	Assistant Director of Nursing	1,952	2,112	113,452	53.72	2
3	Registered Nurses	37,108	45,239	1,915,300	42.34	3
4	Licensed Practical Nurses	37,349	44,815	1,664,459	37.14	4
5	CNAs & Orderlies	72,270	91,482	1,894,582	20.71	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,980	10,137	236,110	23.29	8
9	Activity Director	2,112	2,248	41,965	18.67	9
10	Activity Assistants	8,309	9,131	155,769	17.06	10
11	Social Service Workers	7,928	8,816	244,131	27.69	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	4,471	4,923	111,411	22.63	17
18	Housekeepers	41	41	657	16.02	18
19	Laundry	7,397	8,620	117,281	13.61	19
20	Administrator	2,040	2,160	110,534	51.17	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,024	2,152	46,880	21.78	23
24	Clerical	7,782	8,490	155,536	18.32	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,960	2,176	80,697	37.09	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached</u>	6,448	7,580	188,888	24.92	33
34	TOTAL (lines 1 - 33)	210,291	252,394	\$ 7,243,704 *	\$ 28.70	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 1,200,461	01-03	35
36	Medical Director	Monthly	22,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	54,695	10-03	38
39	Pharmacist Consultant	Monthly	6,206	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	1,461	11-03	44
45	Social Service Consultant	Monthly	2,718	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 1,287,541		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	171	12,852	10-03	51
52	Certified Nurse Assistants/Aides	680	28,561	10-03	52
53	TOTAL (lines 50 - 52)	851	\$ 41,413		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Victoria Gomboc	Administrator	0	\$ 110,534
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 110,534
B. Administrative - Other			
Description			Amount
		\$	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$
C. Professional Services			
Vendor/Payee	Type		Amount
Marcum LLP	Accounting	\$	1,457
ProPay HR	Payroll Processing		28,401
Onyx Procurement Solutions	Procurement Services		12,770
Achieve Accreditation	Accreditation Services		10,592
Telemedicine Solutions	Risk Prevention Services		5,308
Compligent	Compliance		2,043
Cortex Health Inc	Data Processing		10,365
Hygieneering, Inc.	Hygiene & Safety Consulting		1,103
Personnel Planners	Unemployment Consult		1,410
Prospect Resources	Energy Procurement		900
See Attached	Legal		28,302
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 102,651
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	130,783
Unemployment Compensation Insurance			18,570
FICA Taxes			554,143
Employee Health Insurance			199,211
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Employee Benefits			19,264
401K Expense			34,790
Voluntary Benefit Contributions			20,060
Employee Physical Exams			2,905
TOTAL (agree to Schedule V, line 22, col.8)			\$ 979,726
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
		\$	
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee		\$	1,990
Advertising: Employee Recruitment			468
Health Care Worker Background Check (Indicate # of checks performed)	106		1,061
Patient Background Checks	77		779
Dues & Subscriptions			37,107
Licenses & Fees			1,108
See Supplemental Schedule			3,888
Less: Public Relations Expense		(	)
Non-allowable advertising		(	)
Yellow page advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 46,401
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			
Seminar Expense			284
See Supplemental Schedule			155
Entertainment Expense		(	)
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	439

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

- | | |
|--|--|
| <p>(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>No</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report? <u>Yes</u>
If YES, give association name and amount. <u>IHCA \$19,227 ; HCCI \$29,094</u></p> <p>(3) Did the nursing home make political contributions or payments to a political action organization? <u>Yes</u> If YES, have these costs been properly adjusted out of the cost report? <u>Yes</u></p> <p>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>No</u> If YES, what is the capacity? <u>N/A</u></p> <p>(5) Have you properly capitalized all major repairs and equipment purchases? <u>Yes</u>
What was the average life used for new equipment added during this period? <u>10 Years</u></p> <p>(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>50,198</u> Line <u>10</u></p> <p>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>Yes</u> If NO, attach a complete explanation.</p> <p>(8) Are you presently operating under a sale and leaseback arrangement? <u>No</u>
If YES, give effective date of lease. <u>N/A</u></p> <p>(9) Are you presently operating under a sublease agreement? YES <u>X</u> NO</p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES <u> </u> NO <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. <u>N/A</u></p> <p>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ <u>363,293</u>
This amount is to be recorded on line 42 of Schedule V.</p> <p>(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? <u>No</u> If YES, attach an explanation of the allocation.</p> | <p>(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? <u>Yes</u></p> <p>(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? <u>No</u> For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.</p> <p>(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ <u> </u> Has any meal income been offset against related costs? <u>Yes</u> Indicate the amount. \$ <u>N/A</u></p> <p>(16) Travel and Transportation
a. Are there costs included for out-of-state travel? <u>No</u>
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>No</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ <u>N/A</u>
c. What percent of all travel expense relates to transportation of nurses and patients? <u>100% Ln 14</u>
d. Have vehicle usage logs been maintained? <u>No</u>
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>N/A</u>
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>N/A</u>
g. Does the facility transport residents to and from day training? <u>No</u>
Indicate the amount of income earned from providing such transportation during this reporting period. \$ <u>N/A</u></p> <p>(17) Has an audit been performed by an independent certified public accounting firm? <u>No</u>
Firm Name: <u>N/A</u></p> <p>(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>Yes</u></p> <p>(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. <u>Yes</u>
Attach invoices and a summary of services for all architect and appraisal fees.</p> |
|--|--|